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Changing the Air Force Disqualification Policy for Post-Traumatic Stress Disorder and Other Trauma-Related Disorders

John E. Heaton, M.A., Joe Wood, PsyD

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Air Force Research Laboratory
711th Human Performance Wing
U.S. Air Force School of Aerospace Medicine
Aerospace Medicine Department
2510 Fifth St.
Wright-Patterson AFB, OH 45433-7913

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14. ABSTRACT

The U.S. Air Force has traditionally disqualified (i.e., grounded) aviators with mental health disorders resulting from traumatic experiences, such as post-traumatic stress disorder. Following successful treatment, aviators have been required to demonstrate at least 6 months of stability before they were considered fit to return to flying status. However, in the experience of the Neuropsychiatry Branch of the Aeromedical Consultation Service, many of these aviators with prolonged disqualifications have not exhibited functional impairment that interfered with safety of flight. In an effort to return effectively treated aviators to duty sooner, the Air Force has chosen to modify the disqualification policy for trauma-related conditions. The updated policy is designed to ensure flight safety while encouraging aviators with post-traumatic stress disorder to proactively seek mental health treatment.

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1.0 SUMMARY

The U.S. Air Force has traditionally disqualified (i.e., grounded) aviators with mental health disorders resulting from traumatic experiences, such as post-traumatic stress disorder. Following successful treatment, aviators have been required to demonstrate at least 6 months of stability before they were considered fit to return to flying status. However, in the experience of the Neuropsychiatry Branch of the Aeromedical Consultation Service, many of these aviators with prolonged disqualifications have not exhibited functional impairment that interfered with safety of flight. In an effort to return effectively treated aviators to duty sooner, the Air Force has chosen to modify the disqualification policy for trauma-related conditions. The updated policy is designed to ensure flight safety while encouraging aviators with post-traumatic stress disorder to proactively seek mental health treatment.

2.0 INTRODUCTION

After over a decade of conflict in support of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), the impact of post-traumatic stress disorder (PTSD) on soldiers has garnered significant attention. There is evidence that the prevalence rate of PTSD is rising among OIF/OEF veterans, along with the corresponding costs for treatment and disability compensation [1]. Combat deployments are inherently dangerous and increase the risk for exposure to traumatic events. According to Ursano et al. and the Department of Veterans Affairs, early intervention and treatment can be essential to preventing long-term chronic symptoms associated with PTSD [2,3]. To encourage Airmen to seek treatment and return them to flying safely, the United States Air Force (USAF) has recently modified its aeromedical policy for aircrew and special duty personnel diagnosed with PTSD.

According to the latest version of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), a PTSD diagnosis requires exposure to one or more traumatic events where actual or threatened death, serious injury, or sexual violence directly or indirectly occurred. It is characterized by intrusive symptoms, typically flashbacks, intrusive memories/dreams, persistent avoidance of associated stimuli, as well as hypervigilance causing significant distress in social, occupational, or other important areas of functioning. Symptoms must last at least 1 month to meet criteria for a diagnosis of PTSD. Traumatic events can include sexual abuse, violence, combat or deployment-related military service, as well as exposure to traumatic incidents in support of humanitarian/military operations (i.e., intel/cyber warfare operators, rescue and recovery personnel, or assisting with terroristic and natural disasters operations). Like PTSD, acute stress disorder (ASD) and adjustment disorder fall under the section labelled “Trauma- and Stressor-Related Disorders” [4]. These two conditions are generally characterized by a less severe/shorter term emotional reaction to the potentially threatening precipitating event, where the member has a quicker recovery.

The Neuropsychiatry Branch of the Aeromedical Consultation Service (ACS) at the USAF School of Aerospace Medicine (USAFSAM) specializes in evaluating aircrew for a variety of disqualifying medical and mental health related conditions. These clinicians in the fields of aviation psychology, neuropsychology, and psychiatry believe that misdiagnosis can have a potentially negative outcome for aviators as well as their perception of mental health care. The goal of the aeromedical/occupational evaluation is to make a recommendation as to the service member’s readiness to return to flying status (RTFS). Depending on the length, type, and

severity of psychiatric illness, most aircrew and special duty personnel are disqualified for a short-term period to meet established aeromedical waiver criteria set forth by Air Force Instruction 48-123, *Medical Examinations and Standards* [5], and the Medical Standards Directory*. These guidelines provide the service member the opportunity to seek treatment and resolve symptoms of PTSD without the need for a waiver. PTSD becomes a disqualifying diagnosis (i.e., requires a waiver) when one of the following occurs: symptoms and treatment last longer than 60 days, the member has a recurrence of symptoms after returning to duties, or symptoms pose a significant risk to the member, flight safety, or the mission. In any of these circumstances, a waiver would be necessary to return to operational duties. To qualify for the waiver, the member needs to show stability by being asymptomatic and off all medications and treatment for at least a 6-month period [6].

Through the collective knowledge gained from PTSD research, case reviews, and in-person evaluations, the Neuropsychiatry Branch has discovered that not all individuals with PTSD posed a significant risk to self, safety, or mission. When safety is not a concern, according to the judgment of flight surgeon and/or mental health providers, and the temporary emotional reaction is related to operational stress and reactions to combat, a less career-impacting diagnosis would be more appropriate. In some cases of PTSD, the level of functional impairment is similar to that of an adjustment disorder. When treated like an adjustment disorder, USAF flight surgeons can temporarily disqualify, also known as DNIF (duty not including flying), any pilot or aircrew member when safety is a concern to the member, mission, or flight and recommend short-term treatment to work toward symptom resolution. A diagnosis of adjustment disorder may be more appropriate with these short-term, emotionally distressing situations, where safety is not of concern and PTSD is not the more accurate diagnosis. This temporary removal from duties can be beneficial and allow the member to recover from the emotional impact of operational or combat-related stress and return to baseline functioning.

Functional impairment can be assessed relatively easy in the general population, where health, social, occupational, or other areas of functioning are affected by the disorder. However, USAF aircrew and special duty personnel are composed of generally healthy men and women. Herrell et al. argues that occupational impairment is difficult to measure in high functioning professionals, like that of USAF aviators [7]. The occupational demands of these warfighters require them to maintain rigorous physical standards and remain ready to deploy. Military "working occupations" are exposed to more physical and psychological stressors compared to the general public. Therefore, accurately measuring levels of functional impairment given the occupational demands of this population is essential and is addressed in their study of U.S. soldiers. During mental health evaluations at the ACS, aviators with PTSD have shown limited occupational impairment. This finding is helping to shape aeromedical policy and standards for trauma- and stressor-related disorders in USAF aviators.

3.0 METHODS

A database used to track flying waivers, Patient Status Worksheet, was used to gather patient demographic information (e.g., gender, rank, flying class, and ACS recommendation). ACS clinical records were searched for DSM-5 trauma- and stressor-related disorders,

* U.S. Air Force. Medical standards directory. 2014. [Accessed 1 Jun 2014]. Available from https://kx2.afms.mil/kj/kx4/FlightMedicine/Documents/Medical Standards Directory (MSD)/MSD 2014-02-14.docx to those with access.

specifically PTSD, ASD, and adjustment disorders, as well as the various areas of functional impairment. The Aeromedical Information Management Waiver Tracking System was used to collect and confirm final major command disposition (medically acceptable or disqualified) and whether an RTFS waiver was granted. Waiver disposition is unavailable for years prior to 2001; therefore, it will not be analyzed in this study.

The Neuropsychiatry Branch evaluated nearly 2,000 cases (1994-2014) with mental health conditions. These evaluations consisted of either case review only or in-person evaluation. The target population of this study consists of aircrew and special duty personnel sent to the ACS for their first in-person evaluation for PTSD. Therefore, case review only and subsequent in-person evaluations for these personnel were eliminated from this analysis. The following are a few common diagnoses and the number of patients evaluated for each between years 2000-2014: PTSD (30), adjustment disorder (131), and ASD (3).

Given the focus of this paper is on the changes in USAF policy regarding aviators with PTSD, those diagnosed with adjustment disorder and ASD were not examined. Of those evaluated for PTSD, there were 25 (83.33%) males and 5 (16.67%) females. There were 24 (80%) Caucasians, 2 (6.67%) African Americans, 2 (6.67%) Hispanics, and 2 (6.67%) other. Military grades were as follows: 2 (6.67%) E2-E4, 5 (16.67%) E5-E6, 6 (20%) E7-E8, 8 (26.67%) O1-O3, 7 (23.33%) O4-O6, and 2 (6.67%) Reserve Officer Training Corps. There were 3 (10%) Flying Class (FC) I/IA (e.g., student pilot trainee, navigator trainee), 12 (40%) FC II (e.g., rated pilots, navigators, flight surgeon duties), 10 (33.33%) FC III (e.g., airborne, pararescue, combat control), and 5 (16.67%) ground-based controller (air traffic controller, weapons controller/directors). As for marital status at time of ACS evaluation, there were 6 (20%) single, 20 (66.67%) married, 2 (6.67%) divorced, and 2 (6.67%) unknown.

4.0 RESULTS

There were 30 Neuropsychiatry Branch in-person evaluations conducted with subsequent waiver recommendations from 2000 through April 2014; 28 (93.33%) were given an RTFS recommendation and 2 (6.67%) did not receive such a recommendation. In the case of the two disqualifications, one had some professional and pastoral counseling, the other did not have any treatment, and both were still exhibiting symptoms at time of evaluation. These aviators were recommended to successfully complete a course of cognitive-behavioral therapy and pharmacotherapy then reapply for a waiver once asymptomatic without medications for at least 6 months.

In terms of functional impairment, either social and/or occupational, 13 (43.33%) reported only social impairment, zero reported only occupational impairment, and 9 (30%) had occupational and social impairment as a result of exposure to symptoms associated with PTSD. However, not all who had social impairment had occupational impairment (Figure 1).

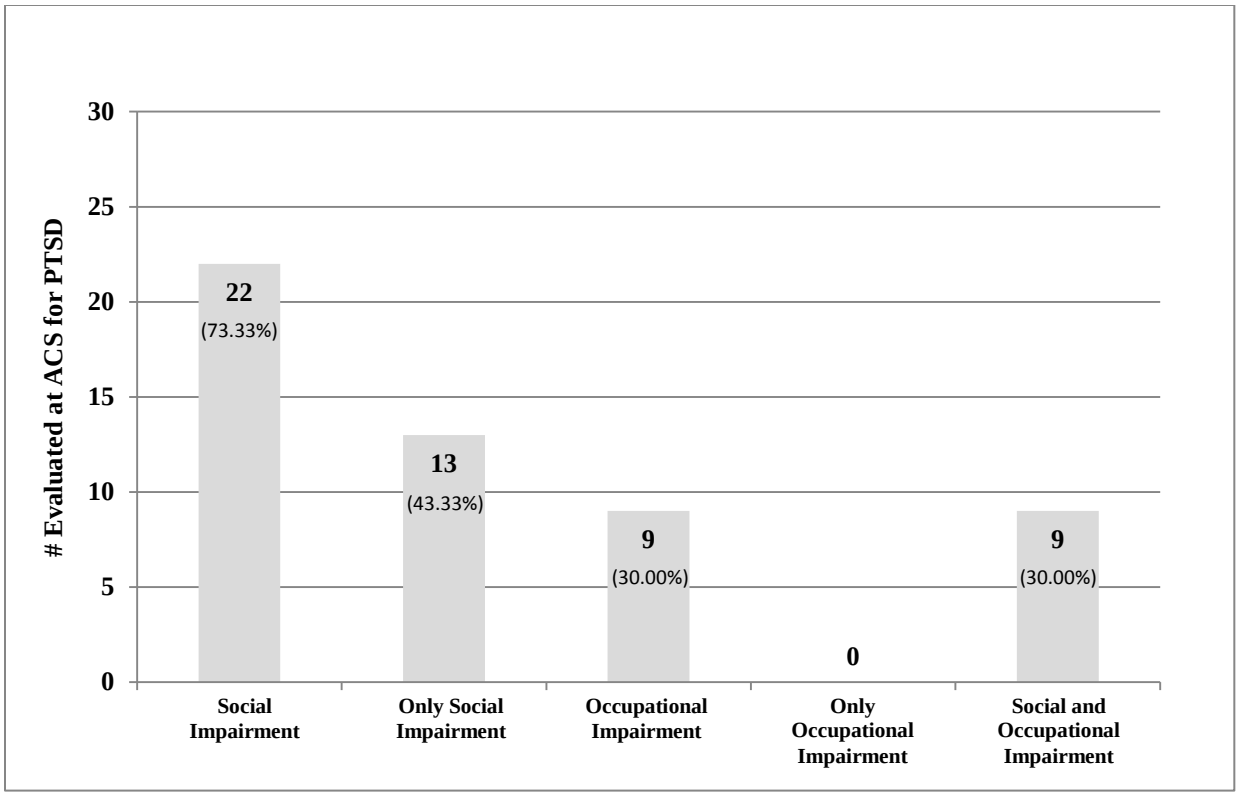

Figure 1. Functional impairment levels of USAF aircrew and special duty personnel evaluated at the ACS

5.0 DISCUSSION

Results of this study indicate that even prior to treatment, the majority of aviators (70%) diagnosed with PTSD exhibited no significant occupational impairment. Most of them did have some form of social impairment (73%), which was primarily characterized by social withdrawal and/or relational discord with family. Anger, irritability, and isolation from co-workers were the main sources of occupational impairment, resulting in fights with co-workers, being relieved of duty/command positions, or being pulled from flying duties. All those with occupational impairment also had some form of social impairment, but none had solely occupational impairment. For the pilot and aircrew communities, withdrawing socially goes against the cultural norm, where camaraderie and unit cohesion are instrumental to mission effectiveness. If occupational areas are affected by a display of emotional reactions, and this is noticed by others in these communities, it can often be perceived as a sign of weakness, and relationships can be strained, potentially having career-impacting consequences. The evidence shows that very few individuals are negatively impacted by PTSD within their occupational environment. These findings suggest that these individuals have less severe PTSD symptoms than their general population peers. This would be expected, given the enhanced medical and mental health standards that USAF aviators must pass prior to being accepted into the field. Additionally, there is evidence that these aviators are intellectually superior [8] and have personality characteristics, such as below-average neuroticism and above-average extraversion [9], that are considered protective factors for developing mental health conditions.

Waiver rates for aviators diagnosed with PTSD are 90%. This suggests that these aviators were evaluated and adequately treated with empirically validated treatments for PTSD, have been able to continue their operational duties despite having PTSD symptoms, and pose minimal risk to self, mission, or flight safety. The two cases evaluated by the ACS who did not receive a waiver recommendation were not adequately treated for PTSD and, therefore, were recommended to seek mental health treatment before being reconsidered for an aeromedical waiver to return to operational duties. Allowing aviators to continue to function in their job to the fullest extent possible while maintaining flight safety removes barriers to care and facilitates aviator treatment. The new policy requires mental health and flight medicine clinics to determine when DNIF time is appropriate and when members should be disqualified for their disorder. The expectation, however, is for eventual return to baseline functioning.

6.0 CONCLUSION

Maintaining a mentally healthy aircrew and special duty population is crucial for the operational readiness of the USAF. The Air Force's decision to change aeromedical policy and standards reflects current PTSD research, and findings demonstrate the Air Force's commitment to its personnel, operations, and flight safety. Due to the demands placed on troops by multiple deployments and high operational tempo, it is crucial that they are properly diagnosed and treated for PTSD and other trauma-related disorders. The goal of the revised aeromedical policy is to improve the mental health of the force and ensure that warfighters are returned to duty as soon as possible.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACS	Aeromedical Consultation Service
ASD	acute stress disorder
DNIF	duty not including flying
DSM-5	Statistical Manual of Mental Disorders, 5th Edition
FC	Flying Class
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PTSD	post-traumatic stress disorder
RTFS	return to flying status
USAF	United States Air Force
USAFSAM	United States Air Force School of Aerospace Medicine